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CLICK HERE FOR THE CEO'S REPORT DATED OCTOBER 2, 2012

CLICK HERE FOR THE CEO'S REPORT DATED NOVEMBER 2, 2012

CLICK HERE FOR COUNTY COUNSEL'S REPORT DATED NOVEMBER 19, 2012

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
500 West Temple Street, Room 713, Los Angeles, California 90012
(213) 974-1101
http://ceo.lacounty.gov

WILLIAM T FUJIOKA
Chief Executive Officer

October 2, 2012

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

STRENGTHENING THE 241.1 PROJECT AND DELINQUENCY PREVENTION PILOT FOR CROSSOVER YOUTH

On September 4, 2012, a motion by Supervisor Ridley-Thomas directed the Chief Executive Officer (CEO), in conjunction with the Juvenile Court and the Departments of Mental Health (DMH), Health Services (DHS), Public Health (DPH), Public Defender, Children and Family Services (DCFS) and Probation, to report back in 30 days on the following issues relating to enhancing services for transition-aged youth and preventing crossover into Probation; and direct DCFS and Mental Health to concurrently work with County Counsel and the CEO to identify funds, in conjunction with the County's Mental Health Commission and Commission for Children and Families, and expedite a process that comports with State law to support these programs:

1) Develop strategies to better serve crossover youth, including strengthening DCFS' Delinquency Prevention Pilot and Countywide expansion of the 241.1 Crossover Youth Project. This report should include the exploration of additional staffing, whether in-house or contracted, improved coordination and oversight, and all corresponding possible funding sources, including the feasibility of using MHSA funds through a mid-year adjustment to the plan;

2) Determine the specific means by which the efficacy and outcomes of the Delinquency Prevention Pilot and 241.1 Crossover Youth Project will be evaluated upon 12 months of implementation, in conjunction with the participating departments, to determine how success will be measured pursuant to the findings of the 2011 Conrad N. Hilton Report; and

3) Request the CEO, County Counsel, and DMH to report back with a careful explanation of the Mental Health Services Act.

The CEO created a project plan which outlines the scope and deliverables of this motion, and established three workgroups to address them. The first workgroup, chaired by the CEO, includes representatives from DMH, DPH, DCFS, DHS, Probation, Public Defender, Juvenile Court, and County Counsel and is focusing on the program analysis and evaluation of the two crossover projects. The second workgroup, also chaired by the CEO, includes representatives from DMH, DCFS, and County Counsel, in consultation with the County's Mental Health Commission and Commission for Children and Families, and is developing funding recommendations for the projects. The third workgroup, chaired by County Counsel, includes representatives from the CEO and DMH, and is drafting a report for the Board that carefully explains the Mental Health Services Act. These workgroups either have begun meeting and/or are scheduled to meet several times over the next few weeks.

It has been determined that additional time is needed to finalize the program and fiscal analysis and evaluation. Therefore, we request a 30-day extension to complete this report.

If you have any questions or need additional information, please contact me, or your staff may contact Antonia Jiménez at (213) 974-7365, or via e-mail at ajimenez@ceo.lacounty.gov.

WTF:AJ:TP
CDM:eb

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Commission for Children and Families
Health Services
Juvenile Court
Mental Health
Mental Health Commission
Probation
Public Defender
Public Health

County of Los Angeles
CHIEF EXECUTIVE OFFICE
Kenneth Hahn Hall of Administration
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WILLIAM T FUJIOKA
Chief Executive Officer

November 2, 2012

To: Supervisor Zev Yaroslavsky, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

STRENGTHENING THE 241.1 PROJECT AND DELINQUENCY PREVENTION PILOT FOR CROSSOVER YOUTH

On September 4, 2012, a motion by Supervisor Ridley-Thomas directed the Chief Executive Officer (CEO), in conjunction with the Juvenile Court and the Departments of Mental Health (DMH), Health Services (DHS), Public Health (DPH), Public Defender, Children and Family Services (DCFS), and Probation, to report back in 30 days on the following issues relating to enhancing services for transition-aged youth and preventing crossover into Probation; and direct DCFS and DMH to concurrently work with County Counsel and the CEO to identify funds, in conjunction with the County's Mental Health Commission and Commission for Children and Families, and expedite a process that comports with State law to support these programs:

1) Develop strategies to better serve crossover youth, including strengthening DCFS' Delinquency Prevention Pilot and Countywide expansion of the 241.1 Crossover Youth Project. This report should include the exploration of additional staffing, whether in-house or contracted, improved coordination and oversight, and all corresponding possible funding sources, including the feasibility of using MHSA funds through a mid-year adjustment to the plan;

2) Determine the specific means by which the efficacy and outcomes of the Delinquency Prevention Pilot and 241.1 Crossover Youth Project will be evaluated upon 12 months of implementation, in conjunction with the participating departments, to determine how success will be measured pursuant to the findings of the 2011 Conrad N. Hilton Report; and

3) Request the CEO, County Counsel, and DMH to report back with a careful explanation of the Mental Health Services Act.

The CEO created a project plan which outlined the scope and deliverables of the first two parts to this motion, and established two workgroups to address them. The first workgroup, chaired by the CEO, included representatives from DMH, DPH, DCFS, DHS, Probation, Public Defender, Juvenile Court, and County Counsel and focused on the program analysis and evaluation of the two crossover projects. The second workgroup, also chaired by the CEO, included representatives from DMH, DCFS, and County Counsel, in consultation with the County's Mental Health Commission and Commission for Children and Families, and developed recommendations for possible funding sources for the projects. The third part of this motion regarding the explanation of the Mental Health Services Act is being reported to you separately.

Attached is a report detailing the final recommendations developed by the two workgroups. The report includes data on the crossover population, programmatic and staffing analyses, fiscal considerations, and evaluation information. There are ten recommendations covering the areas of staffing (pages 12-15, 19), legislation (page 15), mental health and substance abuse resources (pages 15-16, 24), and evaluation of the two projects (pages 17, 19-21). The annual projected cost for implementing the 241.1 recommendations is $1.715 million. There is no projected cost identified for implementing the DCFS Delinquency Prevention Pilot recommendations.

If you have any questions or need additional information, please contact me, or your staff may contact Antonia Jiménez at (213) 974-7365, or via e-mail at ajimenez@ceo.lacounty.gov.

WTF:AJ:TP
CDM:SMF:km

Attachment

c: Executive Office, Board of Supervisors
County Counsel
Children and Family Services
Commission for Children and Families
Health Services
Juvenile Court
Mental Health
Mental Health Commission
Probation
Public Defender
Public Health

Crossover Youth Board Motion

Los Angeles County Board of Supervisors

Supervisor Zev Yaroslavsky, Chairman

Supervisor Gloria Molina

Supervisor Mark Ridley-Thomas

Supervisor Don Knabe

Supervisor Michael D. Antonovich

November 2012

Table of Contents

Executive Summary

Background

On September 4, 2012, Supervisor Mark Ridley-Thomas filed a motion directing the County departments of the Chief Executive Office (CEO), Mental Health (DMH), Health Services (DHS), Public Health (DPH), Public Defender, Children and Family Services (DCFS), Probation, and County Counsel, along with the Juvenile Court, to develop recommendations for enhancing services to transition-aged youth under the jurisdiction of DCFS to prevent them from crossing over into the delinquency system. Specifically, we were asked to develop strategies to strengthen the 241.1 Crossover Youth project and the DCFS Delinquency Prevention Pilot. The recommendations were to focus on the evaluation of staffing resources, contracting out services, improved coordination and oversight, and the efficacy and outcomes of both initiatives. In addition, the workgroup was asked to explore possible funding options for both projects, particularly the feasibility of using Mental Health Services Act (MHSA) funds.

In 2011, a report issued by the Conrad N. Hilton Foundation found that transition-aged youth who had been involved in both the dependency and delinquency systems fared significantly worse as young adults than youth who had only been involved in one of these systems. According to the report, crossover youth were 50 percent less likely to be employed, twice as likely to be on public assistance, and three times more likely to have spent time in jail than their counterparts.

In addition, a recent study conducted by the Children's Research Center estimated that seven percent of youth between the ages of 7 and 15 who are being served by DCFS are at risk of crossing over into the delinquency system. Despite the fact that the number of DCFS-supervised children in out-of-home care has steadily dropped from 26,000 in 2004 to 19,000 in 2012, the number of youth who are arrested has remained constant at approximately 100 per month.

Funding Projections

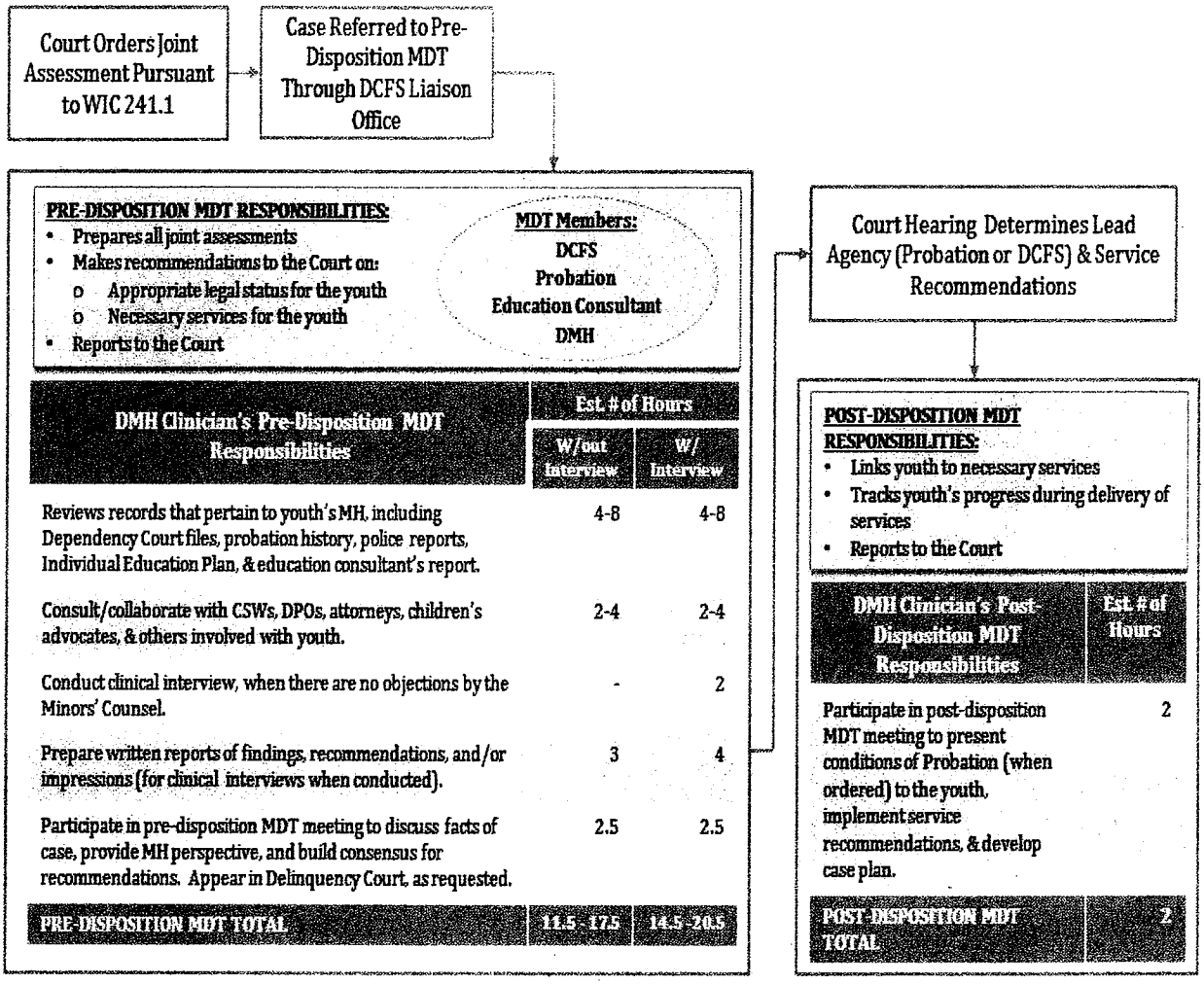
The annual projected cost for implementing the 241.1 recommendations below is $1.715 million. There is no projected cost identified for implementing the DCFS Delinquency Prevention Pilot recommendations.

241.1 Recommendations

On October 8, 1997, Los Angeles County adopted its first comprehensive Welfare and Institutions Code (WIC) Section 241.1 protocol, designed to better serve youth who cross between the dependency and delinquency systems. The protocol required DCFS and Probation to prepare joint assessments for each child involved in the dependency and delinquency systems, and to recommend to the delinquency court which system could best serve the interest of the child and the community. In 2004, WIC Section 241.1 was amended by Assembly Bill (AB) 129 to grant counties the option of adopting a protocol for dual status. As a result, the AB 129 protocol was

developed with the Juvenile Court, Probation, DCFS, DMH and cross-system partners. This protocol created the dual status option to allow all youth assessed under WIC Section 241.1 to receive enhanced case assessment by a Multidisciplinary Team (MDT). In May 2007, the protocol was launched in the Pasadena Delinquency Court as a pilot. A multidisciplinary oversight committee, chaired by the Presiding Judge of the Juvenile Court, monitored the pilot and managed its expansion. In January 2012, the protocol was implemented Countywide (Illustration 1).

Illustration 1: 241.1 Process



As part of this protocol, the MDT is formed that is comprised of a DCFS Children's Social Worker (CSW), a Deputy Probation Officer (DPO), a DMH Psychiatric Social Worker (PSW), and an Education Consultant. The MDT convenes pre-disposition to develop recommendations to the court on the most appropriate legal status for the youth (DCFS, Probation, or both) and the support services needed to support the youth. After the disposition hearing, the MDT convenes post-disposition (generally including the youth and caregiver) to discuss implementation of the court ordered and MDT recommended services. The following describes the activities conducted when a DCFS youth is arrested and referred to the 241.1 project:

- Prior to the court hearing, a pre-disposition MDT process is followed:
  - DMH PSW conducts a comprehensive review of records which includes mental health records, Dependency Court files, Probation history, police reports, and Individual Education Plans (IEPs); the DCFS CSW and Probation DPO review all relevant records within their departments.
  - Probation DPO collaborates with the DCFS CSW and DMH, minors' counsel, children's advocates, and others involved with the youth.
  - When there are no objections by the minors' counsel, DMH conducts a clinical interview.
  - The MDT meets and develops recommendations to the Court regarding the appropriate legal status for the youth (jurisdiction under DCFS, Probation, or both) and identifies the services needed to support them.
- The Delinquency Court determines which department is to be the lead agency for the youth and orders conditions of probation (if any) that typically include the MDT recommendations.
- Following the disposition hearing, a post-disposition MDT is held to review the Juvenile Court orders and conditions for probation (if any), and a plan for providing the needed services is developed.

In January 2012, the project was expanded Countywide so that 10 of the 24 Los Angeles County delinquency courts had been designated throughout the County to hear 241.1 project cases. As there are approximately 100 youth who crossover each month, a total of 200 MDTs (100 pre-disposition and 100 post-disposition) are required monthly. Currently, there are six DMH PSWs dedicated to this project; since the number of MDTs is expected to rise, additional staffing will be required. Upon review of the 241.1 process and available staffing and caseload data, the workgroup has developed the following recommendations aimed at enhancing services, improving coordination, and strengthening the efficacy and outcomes of this project. Our recommendations are focused in four primary areas:

Staffing

Recommendation #1: Hire five additional DMH PSWs, for a total of 11 PSWs, to serve the approximately 100 youth arrested monthly and subject to the 241.1 project. PSWs will be co-located in DCFS regional offices in order to improve coordination with other members of the MDT. DMH and DCFS will continue to track the number of MDT meetings that have PSW participation to ensure appropriate staffing levels are maintained.

Funding: The estimated annual cost for these positions, including costs for space and miscellaneous services and supplies, totals approximately $572,000.

- The existing staffing consists of six DMH PSWs, with five of these positions funded by DCFS using Title IV-E funds, and one position funded by DMH using State Realignment funding. However, additional funding from these sources is not currently available.
- A potential financing option would be to use MHSA Community Services and Supports (CSS) – Outreach and Engagement funds, since some of these funds have already been approved for similar types of services (for example, a mental health court diversion program for adults). While there are currently no unallocated MHSA CSS funds available, partial funding for this project could be identified by re-directing unspent client supportive services dollars and funds for vacant positions in other DMH programs.

- This proposed alternate use of allocated, but unspent, MHSA CSS funding to this project would require approval by MHSA stakeholders, and a 30-day public notice prior to implementation.

Legislation

Recommendation #2: Review AB 1405 (2008) and submit revised proposed statutory language to the Legislature aimed at prohibiting the use of incriminating information collected during a clinical interview from being used against youth in court proceedings. The goal is to provide complete protection of the youth's constitutional rights against self-incrimination and effective assistance of counsel. It is hoped this will encourage youth and their counsel to feel comfortable consenting to an interview. A clinical interview would enable the members of the MDT to better identify the services needed by the youth.

Funding: If any proposed legislation were to become law, there could be a need for additional staffing. However, given the uncertainty of such legislation becoming law and how it might affect assessment services if it did, the impact of this recommendation cannot be estimated at this time. Should legislation to this effect become law, staffing resources would need to be re-evaluated based upon service needs.

Mental Health and Substance Abuse Resources

Recommendation #3: Instruct the 241.1 DMH PSWs to provide specific recommendations, when appropriate, as to the type of mental health services a youth needs. The PSWs should communicate with the co-located DMH staff as to which mental health services are most appropriate and which agencies in their service areas they should connect with.

DMH and DCFS will need to monitor the capacity for these mental health services. There may be a need to re-evaluate current resources if availability issues arise in the future.

Recommendation #4: Develop a process for referring crossover youth identified by the MDT to a DPH contracted provider for substance abuse only assessment and treatment services, when needed. Identify additional resources, if necessary and available, to add treatment slots prioritized for crossover youth. Develop a process for tracking the number of youth identified by the MDT as needing substance abuse only treatment services to more accurately determine systemwide need, and the number of these youth who are subsequently assessed, admitted to, and complete the identified services.

Funding: The estimated annual cost for these services is $1,143,000.

- According to preliminary projections from the pilot, an estimated 24 youth per month (288 per year) may need substance abuse assessment and/or treatment services. The estimated annual cost is based on an average projected per client cost of approximately $3,970 per outpatient episode. The estimate does not include any additional DPH staff.

- Given that DPH does not currently receive referrals from the MDT, this new process will increase demands on DPH's youth treatment system which, along with other DPH substance abuse programs, already experienced capacity reductions earlier this fiscal year as a consequence of federal funding reductions. As the Board has identified this population as a priority, additional resources are necessary, to the extent required. Additional resources will increase service capacity and ensure that there are dedicated treatment slots for crossover youth to minimize the use of waitlists once referred. This would be accomplished while also ensuring that dependency only, delinquency only, or non-system involved youth are not then waitlisted as a result of this prioritization and suffer potential consequences due to delays in service.
- The estimated annual cost assumes that all referrals will require and complete treatment. However, not all youth will be assessed as needing treatment and, of those identified, not all will complete treatment for a variety of reasons (e.g. participation is voluntary, lack of transportation). Also, since it is unknown how many of the 241.1 project youth already receive substance abuse services from DPH contractors, the estimate assumes, possibly incorrectly, that these youth are new cases to the system.
- To more accurately identify service needs, utilization and associated costs, DPH will track participation during the first six months of implementation, and periodically thereafter, to determine whether program refinements or cost adjustments are needed.
- Regarding financing options, Probation currently funds approximately one-third of DPH's youth outpatient treatment slots to serve qualifying Probation-involved youth (ages 12 to 21). Neither DCFS nor DMH have funding streams that can be used to provide substance abuse only services. Since MHSA funds can only be used for authorized mental health prevention services, the full estimated annual cost of $1,143,000 would require net County costs.
- It must be noted that Board action is needed for DPH to increase capacity to provide dedicated treatment slots for crossover youth.

Evaluation

Recommendation #5: Report annually on the following 241.1 evaluation measures:
- Legal status of youth as determined by the court (DCFS, Probation, or both)
- Number of MDTs that include DMH PSW participation
- Number of youth with co-occurring mental health and substance abuse disorders in comparison to youth with non-co-occurring substance abuse issues
- Types of MDT service recommendations made
- Number and type of MDT service recommendations implemented (for example, track a sample of 25 cases per month for nine months)
- Recidivism rates within nine months of being referred to the project

Funding: California State University, School of Criminal Justice and Criminalistics, has agreed to continue to conducting the evaluation for this project.

DCFS Delinquency Prevention Pilot (DPP) Recommendations

While the 241.1 project is focused on youth who have crossed over into the delinquency system, the DCFS Delinquency Prevention Pilot (Illustration 2) is focused on providing services to youth and their families in order to **prevent** them from crossing over. To that end, on October 2, 2012, DCFS implemented a new pilot project aimed at preventing DCFS youth (for new open cases only) from crossing over into delinquency.

The DPP is designed to identify, early on, high risk factors that if not addressed could lead to youth crossing over into the delinquency system. An assessment tool has been developed to determine which DCFS youth are at high risk for subsequent delinquency. The pilot will test the validity of this tool and whether such an alert system leads to expedited attention to these youth and their unique needs. It will also evaluate whether holding ongoing monthly staff consultations, that review the effectiveness of targeted interventions, help to prevent youth from crossing over into delinquency. Outcomes will be tracked quarterly to determine if the pilot is successful.

The overall DPP process is as follows:

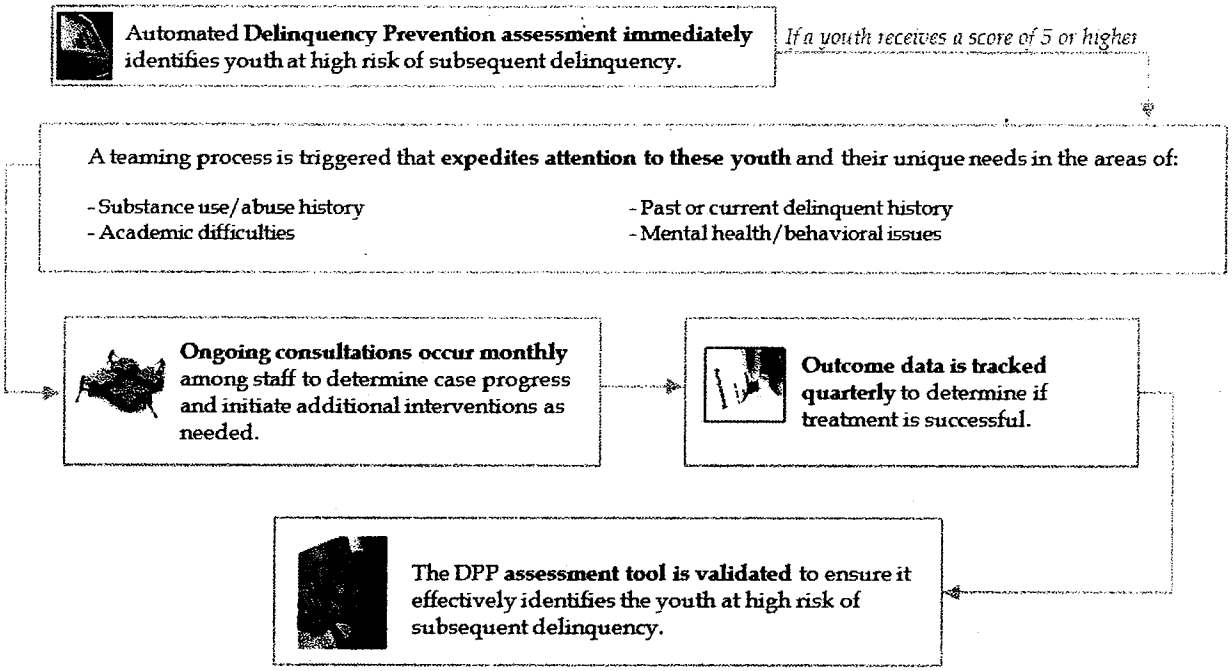
1. The DCFS District Office Assistant Regional Administrator (ARA) and Services Linkage Specialist (SLS) will receive an automated alert that identifies, early on, at-risk youth (for new open cases only) who receive an assessment threshold score between 5 and 10. A score of five or higher indicates that the youth may have substance use and/or abuse history, is failing academically, has past or current delinquency behaviors, and/or has exhibited mental health or behavioral health issues.

2. Upon receipt of the alert, the SLS will immediately consult with the Supervising Children's Social Worker (SCSW) and Children's Social Worker (CSW), and a Multidisciplinary team meeting designed to quickly address the supports and services needed to prevent this youth from crossing over will be held, unless one has already occurred.

3. These teams will consult monthly to conduct ongoing observations, evaluate case progress, and determine if other services and/or additional interventions need to be initiated.

4. On a quarterly basis, DCFS staff will meet to discuss program outcomes, where the team will work to identify areas of success and potential improvement areas.

Illustration 2: DCFS Delinquency Prevention Pilot Process



After reviewing the staffing resources, implementation planning, and evaluation outcomes of the DPP, the workgroup developed the following recommendations:

Recommendation #1: As the pilot is currently being launched, DCFS and DMH are not requesting additional staffing resources. However, the workgroup recommends that an assessment of staffing resources is conducted six months into the pilot.

Recommendation #2: Validate the Structured Decision Making (SDM) Delinquency Implementation Planning Assessment Tool. The Children's Research Center developed this tool, and the pilot will help validate and assess whether the tool appropriately identifies the youth who are at risk of crossing over.

Recommendation #3: Work with DMH to identify targeted interventions with demonstrated success in serving youth who are at risk of crossing over into delinquency, including but not limited to: Functional Family Therapy, Multi-Systemic Therapy, and Aggression Replacement Therapy. Determine what resources are available in these targeted interventions that can be provided to youth in this pilot.

Funding: There are a number of target intervention programs funded through the MHSA Prevention and Early Intervention (PEI) plan. As the need for targeted services is more fully identified, providers may shift PEI funding to deliver those programs most in demand. Since the specific services types and usage for these youth will not be known until implementation is underway, the actual cost for these services cannot be quantified at this time. However,

given the limited scope of the pilot, it is likely that sufficient MHSA PEI funding can be identified to fund any additional treatment services needed.

Recommendation #4: DCFS will develop a process for evaluating the effectiveness of the DPP within the Department.

Recommendation #5: Report quarterly on the DPP outcome measures being tracked. After 12 months, determine if program improvements are needed and whether or not the pilot should be continued and/or expanded.

Introduction

Background Information

A 2011 report by the Conrad N. Hilton Foundation found that transition-aged youth who had been involved in both the dependency and delinquency systems fared significantly worse as young adults than youth who had only been involved in one of these systems. They were 50 percent less likely to be employed, twice as likely to be on public assistance, and three times more likely to have spent time in jail than their counterparts. A recent study conducted by the Children's Research Center estimated that seven percent of youth between the ages of 7 and 15 who are being served by DCFS are at risk of crossing over into the delinquency system. The number of DCFS youth who are arrested has remained constant at approximately 100 per month, despite the fact that the number of children in DCFS-supervised out-of-home care has dropped from 26,000 in 2004 to 19,000 in 2012. As this continues to be a concern, a Board Motion by Supervisor Ridley-Thomas was introduced to examine strengthening two key Los Angeles County projects aimed at preventing youth from crossing over into delinquency, and ensuring they get the services and supervision needed. These projects are the 241.1 Project and the Delinquency Prevention Pilot.

Board Motion

On September 4, 2012, a motion by Supervisor Ridley-Thomas directed the Chief Executive Officer (CEO), in conjunction with the Juvenile Court and the Departments of Mental Health (DMH), Health Services (DHS), Public Health (DPH), Public Defender, Children and Family Services (DCFS) and Probation, to report back in 30 days on the following issues relating to enhancing services for transition-aged youth and preventing crossover into Probation; and direct DCFS and Mental Health to concurrently work with County Counsel and the CEO to identify funds, in conjunction with the County's Mental Health Commission and Commission for Children and Families, and expedite a process that comports with State law to support these programs:

1. Develop strategies to better serve crossover youth, including strengthening DCFS' Delinquency Prevention Pilot and Countywide expansion of the 241.1 Crossover Youth Project. This report should include the exploration of additional staffing, whether in-house or contracted, improved coordination and oversight, and all corresponding possible funding sources, including the feasibility of using Mental Health Services Act (MHSA) funds through a mid-year adjustment to the plan;

2. Determine the specific means by which the efficacy and outcomes of the Delinquency Prevention Pilot and 241.1 Crossover Youth Project will be evaluated upon 12 months of implementation, in conjunction with the participating departments, to determine how success will be measured pursuant to the findings of the 2011 Conrad N. Hilton Report; and

3. Request the CEO, County Counsel, and DMH to report back with a careful explanation of the MHSA.

Objective

To address the Board Motion, the Crossover Youth Workgroup developed the following clear objectives:

- Conduct a staff analysis to determine if additional staffing is needed based on site-specific demands and caseloads.
- Develop recommendations for improved coordination and oversight.
- Determine whether these services should be performed in-house or be contracted out.
- Evaluate and/or develop a comprehensive plan for the implementation of DCFS' Delinquency Prevention Pilot.
- Develop recommendations for tracking the efficacy and outcomes of the Delinquency Prevention Pilot and 241.1 Crossover Youth projects, and develop an evaluation process to track outcomes after 12 months of implementation.
- Determine how program success will be measured pursuant to the findings of the 2011 Conrad N. Hilton Report.

Concurrently, a second workgroup comprised of DMH, DCFS, CEO and County Counsel, in consultation with the County's Mental Health Commission and Commission for Children and Families, were to develop recommendations for possible funding sources.

In a separate correspondence to the Board, County Counsel, in consultation with the CEO and DMH, will provide a careful explanation of the MHSA.

Funding Projections

The annual projected cost for implementing the 241.1 recommendations below is $1.715 million. There is no projected cost identified for implementing the DCFS Delinquency Prevention Pilot recommendations.

241.1 Project Recommendations

Background

On October 8, 1997, Los Angeles County adopted its first comprehensive Welfare and Institutions Code (WIC) Section 241.1 protocol, designed to better serve youth who cross between the dependency and delinquency systems. The protocol required DCFS and Probation to prepare joint assessments for each child involved in the dependency and delinquency systems, and to recommend to the delinquency court which system could best serve the interest of the child and the community. In 2004, WIC Section 241.1 was amended by Assembly Bill (AB) 129 to grant counties the option of adopting a protocol for dual status. As a result, the AB 129 protocol was developed with the Juvenile Court, Probation, DCFS, DMH and cross-system partners. This protocol created the dual status option to allow all youth assessed under WIC Section 241.1 to

receive enhanced case assessment by a Multidisciplinary Team (MDT). In May 2007, the protocol was launched in the Pasadena Delinquency Court as a pilot. A multidisciplinary oversight committee, chaired by the Presiding Judge of the Juvenile Court, monitored the pilot and managed its expansion. In January 2012, the protocol was implemented Countywide.

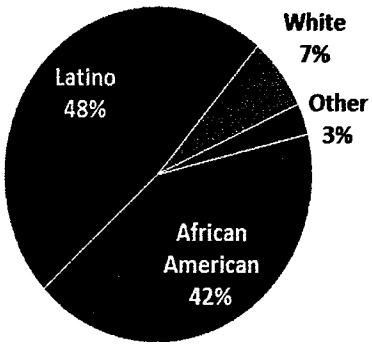
As part of this protocol, the MDT is formed that is comprised of a DCFS Children's Social Worker (CSW), a Deputy Probation Officer (DPO), a DMH Psychiatric Social Worker (PSW), and an Education Consultant. The MDT convenes pre-disposition to develop recommendations to the court on the most appropriate legal status for the youth (DCFS, Probation, or both) and the services needed to support the youth. After the disposition hearing, the MDT convenes post-disposition (generally including the youth and caregiver) to discuss implementation of the court ordered services.

In May 2007, the 241.1 project was launched in the Pasadena Delinquency Court as a pilot protocol for determining the most appropriate legal status (jurisdiction under DCFS, Probation, or both) for DCFS youth who were arrested and proceeding through the delinquency court process. 241.1 is an intervention program aimed at reducing the number of youth who become sole delinquency wards and ensuring that youth are linked with appropriate services to minimize their risk of recidivism. The goal of the pre-disposition MDT is to recommend the least restrictive option (warship, dependency or dual status) and most appropriate level of services needed to meet the needs of the youth and their family, and maintain community safety.

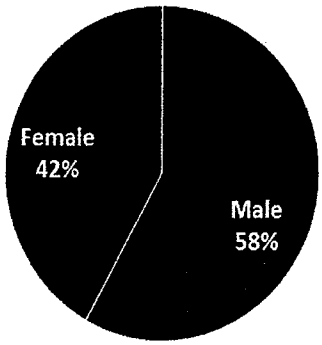
Who These Youth Are:

A youth who falls under the provisions of the 241.1 protocol is one who is under the custody of DCFS, has been arrested, and is entering the delinquency system. A 2012 project evaluation conducted by California State University, School of Criminal Justice and Criminalistics, found that:

Ethnicity



Gender



- The average age at arrest was 15-years-old
- The average length of time spent in DCFS care at time of arrest was six years
- Approximately 50 percent of the arrests occurred at the youth's placement or school

- Only 14 percent of the youth scored high on a delinquency risk assessment (Los Angeles Risk and Resiliency Checkup)
- 52 percent of the youth had special education issues
- 24 percent of the youth had a mental health only issue
- 24 percent of the youth had a substance abuse only issue
- 29 percent of the youth had a co-occurring mental health and substance abuse issue

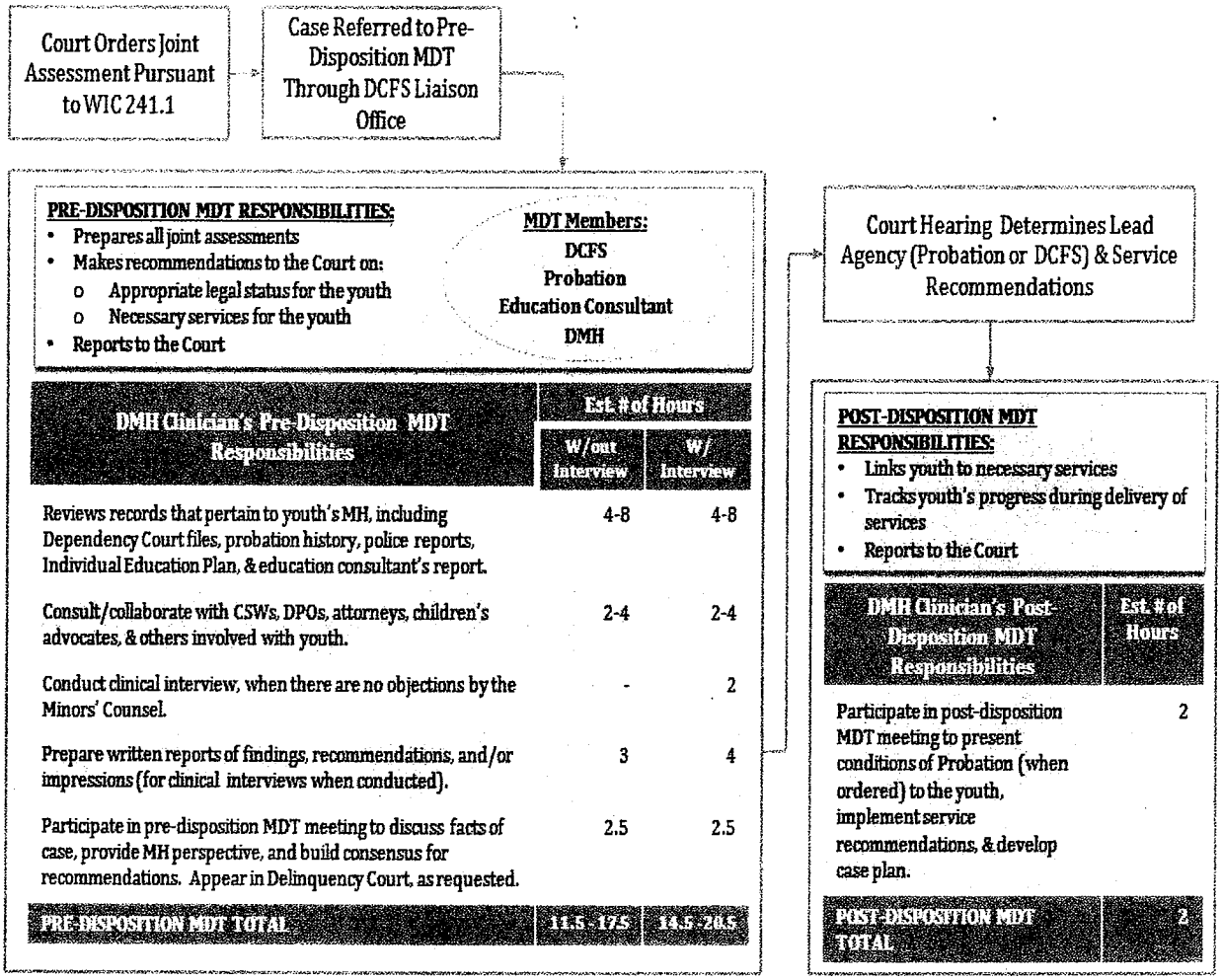
When the project began, there were fears that the majority of these youth would become sole wards of the Delinquency Court. In fact, the opposite has occurred: data collected in 2012 showed that only three percent of the 241.1 youth became sole delinquency wards. The majority of these cases maintain some type of DCFS involvement.

241.1 Protocol Process

As illustrated below, pursuant to WIC Section 241.1, the following occurs for DCFS youth who are arrested and are referred to the 241.1 project:

- When the court orders an assessment pursuant to WIC Section 241.1, a **pre**-disposition MDT is conducted with representatives from DCFS, DMH, Probation and an Education Consultant.
- The MDT develops recommendations regarding the appropriate legal status for the youth (jurisdiction under DCFS, Probation, or both) and identifies the services needed to support the youth.
- The Delinquency Court determines which department is to be the lead agency for the youth and orders conditions of probation (if any) that typically include the MDT recommendations.
- Following the disposition hearing, a **post**-disposition MDT is held to review the Juvenile Court orders and conditions for probation (if any), and a plan for providing the needed services is developed.

Illustration 1: 241.1 Process



241.1 Staffing

In January 2012, the project was expanded Countywide and 10 of the 24 Los Angeles County delinquency courts have been designated throughout the County to hear 241.1 project cases. There are approximately 100 youth who are referred to the project each month. The 241.1 project that began in May 2007 in one juvenile court was originally staffed by three DPOs, four CSWs, and one PSW.

The current staffing levels for the 241.1 project across the 10 juvenile delinquency courts are:

Type of Staff	#	Case-Carrying	Avg Case -load	Responsibilities	Out-Stationed at Court	Location
Probation						
DPO	13[1]	Yes	35	Provide supervision and case management to youth, participate in post-disposition MDTs	No	North East Area East LA Area
Placement DPO	1	Yes	50	Provide supervision and case management to youth, participate in post-disposition MDTs	No	North East Area East LA Area
Investigators	10	No	11	Prepare 241.1 assessments and social histories, participate in pre-disposition MDTs	No	North East Area East LA Area
Children and Family Services						
SCSW (1) CSW (8)	9	No	25	Convene pre- and post-disposition MDTs, review pre-disposition report recommendations, write post-disposition reports, facilitate communication among department staff	Yes	Edelman's Children's Court
Mental Health						
PSWs	6	No	33	Prepare mental health case histories, participate in pre- and post-disposition MDTs	Yes	Edelman's Children's Court*

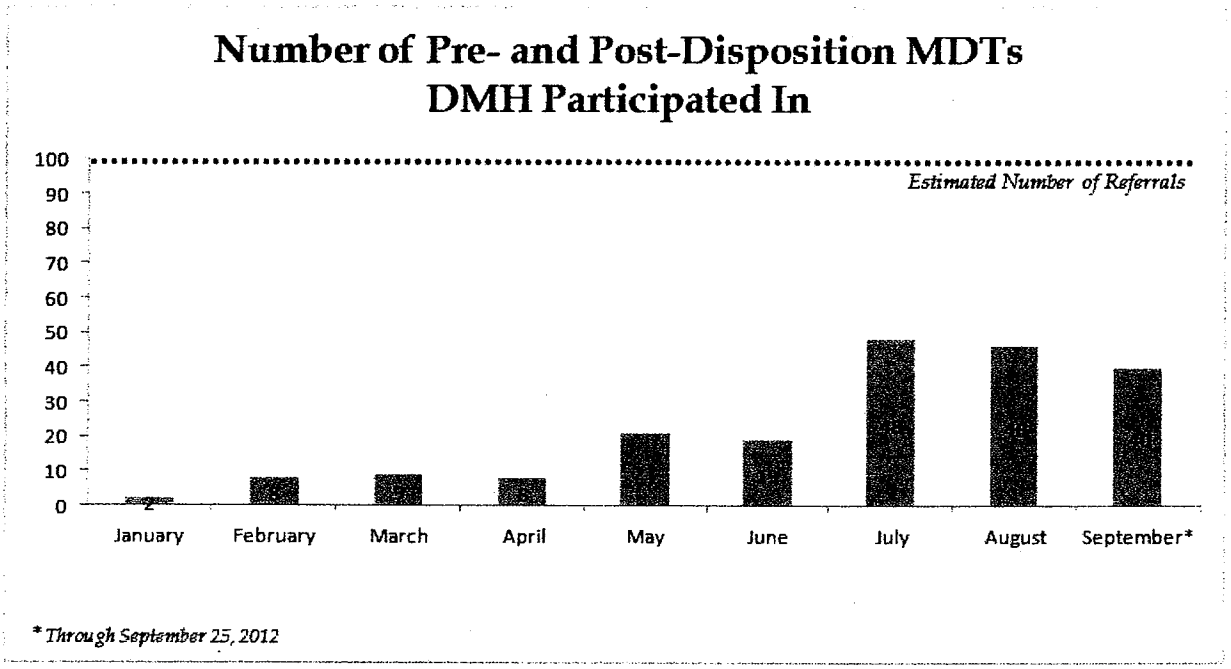
* DCFS is identifying space to move 5 PSWs to their regional offices

[1]13 filled DPOs and 6 vacancies

The PSWs typically spend between 19.5 and 22.5 hours on each case and are responsible for:

- Reviewing all relevant court, department, police, education and other records that pertain to a youth's mental health status;
- Consulting and collaborating with CSWs, DPOs, attorneys, children's advocates, and others involved with the youth; conducting clinical interviews, when there are no objections by minors' counsel to do so;
- Preparing written reports of findings, recommendations, and/or clinical impressions;
- Participating in the pre-disposition MDT meeting to discuss the facts of the case, providing a mental health perspective, and building consensus for the recommendations;
- Appearing in delinquency court proceedings, as requested; and
- Participating in the post-disposition MDT meeting to present the conditions of probation to the youth, implementing the service recommendations, and helping to develop the case plan.

When the 241.1 project was initially created, MDTs were not a part of the original protocol. Yet, their addition to the process has been invaluable for providing youth with the specific support they need to address their unique issues. For example, recidivism rates have been consistently lower for those youth who receive an MDT as part of their protocol (21% with an MDT versus 36% without an MDT, after one-year). As a result, the number of MDTs requested is increasing. In order to support the additional workload for the PSWs, additional staffing is necessary. As the caseloads vary considerably among the 10 project delinquency courts, these workers should be co-located at DCFS regional offices so that they can work closely with the CSWs and more effectively serve all 10 project courts.



Recommendation #1: Hire five additional DMH PSWs, for a total of 11 PSWs, to serve the approximately 100 children arrested monthly and subject to the 241.1 project. PSWs will be co-located in DCFS regional offices in order to improve coordination with other members of the MDT. DMH and DCFS will continue to track the number of MDT meetings that have PSW participation to ensure appropriate staffing levels are maintained.

Funding: The estimated annual cost for these positions, including costs for space and miscellaneous services and supplies, totals approximately $572,000.

- The existing staffing consists of six DMH PSWs, with five of these positions funded by DCFS using Title IV-E funds, and one position funded by DMH using State Realignment funding. However, additional funding from these sources is not currently available.
- A potential financing option would be to use MHSA Community Services and Supports (CSS) – Outreach and Engagement funds, since some of these funds have already been approved for similar types of services (for example, a mental health court diversion program for adults). While there are currently no unallocated MHSA CSS funds available, partial funding for this project could be identified by re-directing unspent client

supportive services dollars and funds for vacant positions in other DMH programs.
- This proposed alternate use of allocated, but unspent, MHSA CSS funding to this project would require approval by MHSA stakeholders, and a 30-day public notice prior to implementation.

Legislative Issues

We have learned through the 241.1 project that while conducting pre-disposition clinical interviews is desirable, very few typically occur. This is due to concerns, often raised by the minors' counsel, that these youth may disclose information during the interview that may be used against them in court. Of the 201 youth DMH served between January and September 2012, only 12 clinical interviews were conducted. Though the concern for protecting the youths' rights is critical, it is also important to have accurate, up-to-date information to ensure the development of an effective case plan.

In 2008, AB 1405 was approved unanimously by both the California State Assembly and Senate, and was vetoed by the Governor at the time. This bill would have offered protection for some of the information a youth might disclose during a clinical interview by prohibiting its use in court proceedings. As a starting point, it may be worthwhile to review this legislation and then consider submitting revised proposed statutory language to the Legislature.

Recommendation #2: Review AB 1405 (2008) and submit revised proposed statutory language to the Legislature aimed at prohibiting the use of incriminating information collected during a clinical interview from being used against youth in court proceedings. The goal is to provide complete protection of the youth's constitutional rights against self-incrimination and effective assistance of counsel. It is hoped this will encourage youth and their counsel to feel comfortable consenting to an interview. A clinical interview would enable the members of the MDT to better identify the services needed by the youth.

Funding: If any proposed legislation were to become law, there could be a need for additional staffing. However, given the uncertainty of such legislation becoming law and how it might affect assessment services if it did, the impact of this recommendation cannot be estimated at this time. Should legislation to this effect become law, staffing resources would need to be re-evaluated based upon service needs.

Mental Health Resources

The pre-disposition MDT, while not regularly included in the original 241.1 protocol, has become an integral part of the process for determining the most appropriate legal status and service referrals. However, caseworkers who are tasked with implementing the MDT recommendations have found it difficult to effectively link youth to appropriate mental health services because these recommendations, for those staff who are not mental health experts, often seem vague and do not provide much direction for what types of mental health services are needed. Additionally, caseworkers are often not as familiar with the array of mental health resources available within their respective communities.

Recommendation #3: Instruct the 241.1 DMH PSWs to provide specific recommendations, when appropriate, as to the type of mental health services a youth needs. The PSWs should communicate with the co-located DMH staff as to which mental health services are most appropriate and which agencies in their service areas they should connect with.

DMH and DCFS will need to monitor the capacity for these mental health services. There may be a need to re-evaluate current resources if availability issues arise in the future.

Substance Abuse Services

As data from the latest evaluation indicates that 53 percent of crossover youth have either a substance abuse only or co-occurring mental health and substance abuse issue, it would appear that substance abuse treatment services need to be an important component of the service referrals generated from the MDT process, and making the linkage faster to these treatment services is critical. However, the Substance Abuse Prevention and Control division within DPH serves an administrative function in regards to provision of substance abuse treatment and does not provide any direct client services; all treatment and prevention services are contracted out to providers.

Recommendation #4: Develop a process for referring crossover youth identified by the MDT to a DPH contractor provider for substance abuse only assessment and treatment services, when needed. Identify additional resources, if necessary and available, to add treatment slots prioritized for crossover youth. Develop a process for tracking the number of youth identified by the MDT as needing substance abuse only treatment services to more accurately determine systemwide need, and the number of these youth who are subsequently assessed, admitted to, and complete the identified services.

Funding: The estimated annual cost for these services is $1,143,000.

- According to preliminary projections from the pilot, an estimated 24 youth per month (288 per year) may need substance abuse assessment and/or treatment services. The estimated annual cost is based on an average projected per client cost of approximately $3,970 per outpatient episode. The estimate does not include any additional DPH staff.
- Given that DPH does not currently receive referrals from the MDT, this new process will increase demands on DPH's youth treatment system which, along with other DPH substance abuse programs, already experienced capacity reductions earlier this fiscal year as a consequence of federal funding reductions. As the Board has identified this population as a priority, additional resources are necessary, to the extent required. Additional resources will increase service capacity and ensure that there are dedicated treatment slots for crossover youth to minimize the use of waitlists once referred. This would be accomplished while also ensuring that dependency only, delinquency only, or non-system involved youth are not then waitlisted as a result of this prioritization and suffer potential consequences due to delays in service.
- The estimated annual cost assumes that all referrals will require and complete treatment. However, not all youth will be assessed as needing treatment and, of those identified, not all will complete treatment for a variety of reasons (e.g. participation is voluntary, lack of

transportation). Also, since it is unknown how many of the 241.1 project youth already receive substance abuse services from DPH contractors, the estimate assumes, possibly incorrectly, that these youth are new cases to the system.

- To more accurately identify service needs, utilization and associated costs, DPH will track participation during the first six months of implementation, and periodically thereafter, to determine whether program refinements or cost adjustments are needed.
- Regarding financing options, Probation currently funds approximately one-third of DPH's youth outpatient treatment slots to serve qualifying Probation-involved youth (ages 12 to 21). Neither DCFS nor DMH have funding streams that can be used to provide substance abuse only services. Since MHSA funds can only be used for authorized mental health prevention services, the full estimated annual cost of $1,143,000 would require net County costs.
- It must be noted that Board action is needed for DPH to increase capacity to provide dedicated treatment slots for crossover youth.

241.1 Project Evaluation

An ongoing evaluation has been conducted by the California State University, School of Criminal Justice and Criminalistics since the inception of this project. Currently, project outcomes are being tracked quarterly and used to determine if additional program improvements are needed. Success of the project has been defined as: provision of the least-restrictive oversight (oversight from DCFS as opposed to Probation), delivery of quality services based on the specific needs of the youth, and reduction in recidivism rates.

Although the evaluation data to date has been instrumental in informing the overall success of this project and providing guidance in its development, there has not been a mechanism in place to allow for the tracking of MDT recommendations actually implemented. This information is critical for ensuring that youth were effectively linked to the services they need. Moving forward, it will be important to begin capturing this data.

Recommendation #5: Report annually on the following 241.1 evaluation measures:

- Legal status of youth as determined by the court (DCFS, Probation, or both)
- Number of crossover youth who receive sole delinquency wardship
- Number of MDTs that include DMH PSW participation
- Number of youth with co-occurring mental health and substance abuse disorders in comparison to youth with non-co-occurring substance abuse issues
- Types of MDT service recommendations made
- Number and type of MDT service recommendations implemented (for example, track a sample of 25 cases per month for nine months)
- Recidivism rates within nine months of being referred to the project

Funding: California State University, School of Criminal Justice and Criminalistics, has agreed to continue to conducting the evaluation for this project.

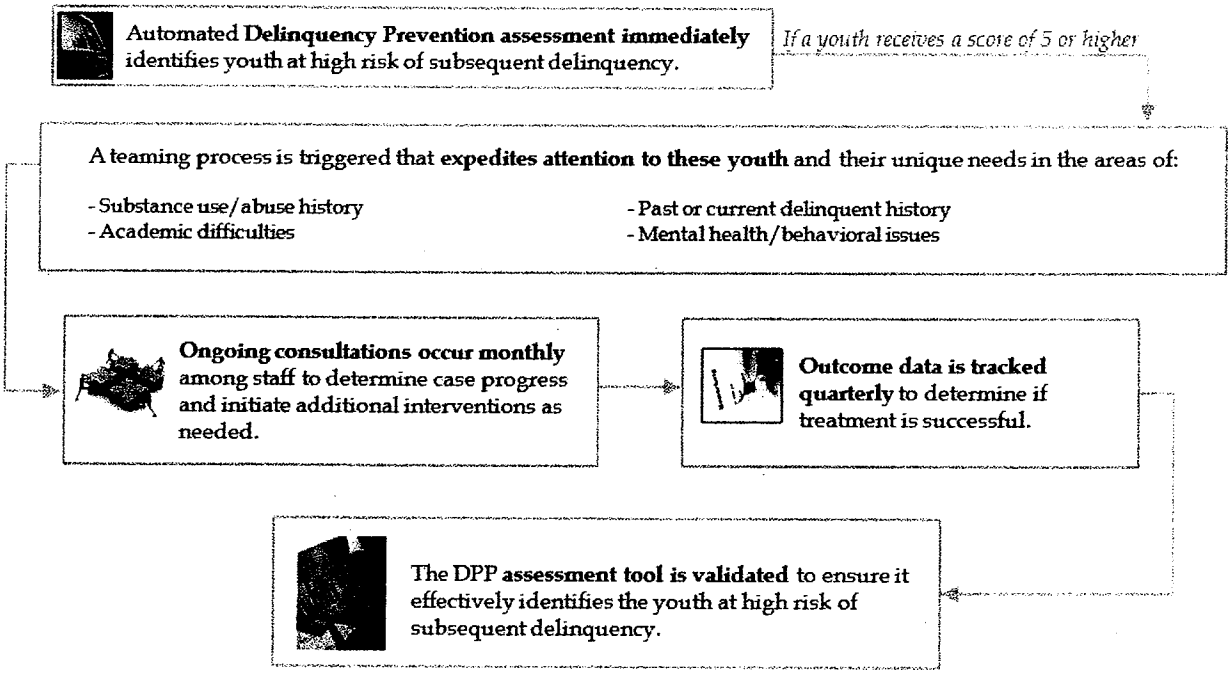
DCFS Delinquency Prevention Pilot (DPP) Recommendations

While the 241.1 project is focused on youth who have crossed over into the delinquency system, the DCFS Delinquency Prevention Pilot (Illustration 2) is focused on providing services to youth and their families in order to **prevent** them from crossing over. To that end, on October 2, 2012, DCFS implemented a new pilot project aimed at preventing DCFS youth (for new open cases only) from crossing over into delinquency. According to research conducted by the Children's Research Center in 2011, seven percent of DCFS youth between the ages of 7 and 15 are at risk for crossing over into the delinquency system.

The DPP is designed to:

- Identify, early on, high risk factors that if not addressed could lead to youth crossing over into the delinquency system
- Validate an assessment tool that has been developed to determine which DCFS youth are at high risk for subsequent delinquency
- Test whether such an alert system leads to expedited attention to these youth and their unique needs
- Evaluate whether holding ongoing monthly staff consultations, that review the effectiveness of targeted interventions, help to prevent youth from crossing over into delinquency
- Track outcomes quarterly to determine if the pilot is successful

Illustration 2: DCFS Delinquency Prevention Pilot Process



This one year pilot has been launched in four DCFS regional offices: South County, Palmdale, Glendora, and Compton. Approximately 50 total staff including CSWs, Service Linkage

Specialists, and Team Decision Making Facilitators have been trained on its components.

Staffing and Caseloads:

This pilot utilizes existing case-carrying staff. Average monthly caseloads of youth identified as high-risk for each pilot office are:

South County	Palmdale	Glendora	Compton
14	9	4	10

DPP Staffing

DCFS and DMH are using their case-carrying CSWs and co-located clinicians to implement this pilot in the four DCFS regional offices, therefore, no additional staffing is recommended at this time. After six months of implementation, DCFS and DMH will re-evaluate the need for additional resources based on workload capacity and revisit their staffing needs.

Recommendation #1: As the pilot is currently being launched, DCFS and DMH are not requesting additional staffing resources. However, the workgroup recommends that an assessment of staffing resources is conducted six months into the pilot.

SDM Delinquency Implementation Planning Assessment Tool

The Children's Research Center created this automated tool that pulls data from DCFS' Structured Decision Making instrument on all new open cases and assesses a youth's risk level for delinquency across ten domains. An overall score is generated, and if a youth receives a score of five or higher, immediate notification is sent to the pilot regional office and the youth is enrolled in the pilot.

Assessment Areas	High-Risk Scoring Factors
1) **Prior investigation(s) for abuse or neglect**	▪If there were 3 or more investigations
2) **Prior CPS services**	▪ If there were 2 or more prior open cases
3) **Prior injury to any child in the home resulting from child abuse/neglect**	▪If any child sustained an injury from abuse/neglect ▪ Prior substantiated abuse to a child with a household member as a perpetrator
4) **Child was placed in a group home as a result of investigation that led to current case**	▪If the child was placed in a group home, whether it was the initial or subsequent placement
5) **Child age at time of CPS referral that led to current case**	▪If the child was 13 years or older
6) **Child gender**	▪ If the child is male
7) **Child substance use/abuse**	▪ If a child's substance use is regular and beyond experimentation and/or results in disruptive behavior or relationships
8) **Child academic difficulty**	▪ If the child is working below grade level or is struggling to meet the goals of the existing educational plan ▪ If the child is school age and is not attending school regularly
9) **Child past or current delinquency**	▪If the child is or has engaged in criminal behavior within the past 2 years (whether know to law enforcement or not)
10) **Child mental health/behavioral issue (any child in the home)**	▪ If any child has a mental health or behavioral issue unrelated to a disability (DSM Axis I diagnosis, receiving MH treatment, in a special classroom due to behavior, or taking psychoactive medication)
	TOTAL SCORE/RISK LEVEL [redacted]

This assessment tool has been beta-tested over the last year within these offices, but it has yet to be validated for its effectiveness in identifying youth at high risk for subsequent delinquency.

Recommendation #2: Validate the Structured Decision Making (SDM) Delinquency Implementation Planning Assessment Tool. The Children's Research Center developed this tool, and the pilot will help validate and assess whether the tool appropriately identifies the youth who are at risk of crossing over.

DPP Process

For all new open cases received by the four pilot DCFS regional offices, the automated assessment tool immediately identifies youth at high risk for subsequent delinquency. If a youth receives a score of five or higher, a teaming process is triggered that quickly addresses the youth's unique needs and refers them to targeted interventions with demonstrated success for youth at risk of crossing over into delinquency. Ongoing monthly consultations are held among staff to determine case progress and initiate additional interventions, as needed. Outcome data is tracked quarterly to determine if treatment is successful.

Recommendation #3: Work with DMH to identify targeted interventions with demonstrated success in serving youth who are at risk of crossing over into delinquency, including but not limited to: Functional Family Therapy, Multi-Systemic Therapy, and Aggression Replacement Therapy. Determine what resources are available in these targeted interventions that can be provided to youth in this pilot.

Funding: There are a number of target intervention programs funded through the MHSA Prevention and Early Intervention (PEI) plan. As the need for targeted services is more fully identified, providers may shift PEI funding to deliver those programs most in demand. Since the specific services types and usage for these youth will not be known until implementation is underway, the actual cost for these services cannot be quantified at this time. However, given the limited scope of the pilot, it is likely that sufficient MHSA PEI funding can be identified to fund any additional treatment services needed.

There is significant alignment between this pilot and the Department's Core Practice Model as this pilot is a highly individualized approach focused on identifying underlying needs of youth and providing targeted support for addressing them. However, it is unique in that it utilizes a research-based tool for assessing risk of subsequent delinquency, activates monthly consultations among staff to continuously evaluate the effectiveness of service interventions and determine if additional team meetings are needed, and tracks outcome data on a quarterly basis. Lessons learned from this pilot will inform the Core Practice Model, as well as other key departmental practices.

DPP Evaluation

Data for the DPP evaluation will be tracked across five outcome areas and reported quarterly to monitor pilot success. Success of the pilot is defined by effectively identifying youth at risk for subsequent delinquency and reducing the number of youth entering the 241.1 process.

To evaluate the pilot, DCFS is developing a Cognos report that will extract data elements available electronically. All other data elements will be inputted manually by each pilot regional office. Data outcomes will be tracked at six months and 12 months for each youth and compared to a sample of at-risk youth in non-pilot offices. Additionally, the evaluation will track the number of youth to subsequently crossover into delinquency who did not receive a five or higher on the assessment tool.

Recommendation #4: DCFS will develop a process for evaluating the effectiveness of the DPP within the Department.

The outcome measures to be tracked quarterly are:

DPP OUTCOME MEASURES	
Delinquent Behavior	▪ Number of arrests ▪ Number of police citations
Substance Abuse	▪ Subsequent drug use ▪ Placement changes due to substance use ▪ Regular participation in treatment
Family Outcomes	▪ Number of new investigated referrals ▪ Reunification with parent ▪ New removals
Mental Health	▪ Regular participation in treatment ▪ Course of treatment completed ▪ Number of hospitalizations/in-patient episodes
Education	▪ Attendance rate ▪ Remained at school of origin ▪ Reason youth left school ▪ Number of suspensions ▪ Number of high school credits earned ▪ High school graduation

Recommendation #5: Report quarterly on the DPP outcome measures being tracked. After 12 months, determine if program improvements are needed and whether or not the pilot should be continued and/or expanded.

Contracting Out 241.1 and DPP Services

The workgroup was unable to identify specific services that could be contracted out as WIC Section 241.1 mandates that DCFS and Probation conduct the joint assessment, and did not see the need to contract out services that are currently provided in-house for either project.

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County Counsel

November 19, 2012

TO: SUPERVISOR ZEV YAROSLAVSKY, Chairman
SUPERVISOR GLORIA MOLINA
SUPERVISOR MARK RIDLEY-THOMAS
SUPERVISOR DON KNABE
SUPERVISOR MICHAEL D. ANTONOVICH

FROM: JOHN F. KRATTLI
County Counsel

RE: **Report on the Mental Health Services Act, including Adoption of Program and Expenditure Plans by County Boards of Supervisors - No Action Necessary**

Purpose of Memorandum

This memorandum responds to your Board's September 4, 2012, directive to the Chief Executive Office ("CEO"), Department of Mental Health ("DMH"), and County Counsel to provide a careful explanation of the Mental Health Services Act ("MHSA or Act"). Below is an explanation of the Act, including a description of your Board's role in the adoption of the MHSA program and expenditure plans, which we prepared following discussions and review with the CEO and DMH.

Summary

The MHSA provides funding to support new and expanded county mental health programs. It requires that MHSA program and expenditure plans "shall be developed with local stakeholders." Recent legislation reaffirms and reinforces this requirement. This same legislation now requires that these stakeholder-developed plans also be adopted by county boards of supervisors prior to submission to the State. Board of supervisors' approval was previously not a requirement for plan submission.

In brief, the MHSA requires that: a County plan be developed with local stakeholders; the plan be posted for public comment; the County Mental Health Commission conduct a public hearing on the plan; and your Board adopt the plan prior to DMH's submission of the plan to the State.

While the requirement for Board adoption creates a role for your Board, in our opinion this requirement does not fundamentally alter the intent of the Act that counties develop plans in collaboration with stakeholders. For this reason, we believe that your Board's role in adopting MHSA program plans is circumscribed: (1) your Board must ensure the plan comports with the substantive and procedural requirements of the Act, and must adopt plans that are in conformity with the Act; (2) your Board is not permitted to unilaterally revise or alter a MHSA program plan because your Board disagrees with the content of the plan; and (3) your Board may not direct MHSA funding to be spent on services or programs not within the scope of a stakeholder-developed plan.

However, before the plans are presented to your Board, DMH and other County departments have had substantial input along with the stakeholders in the identification of specific mental health programs in the plan. Additionally, a plan presented to your Board for adoption could be referred back to the stakeholder process for further consideration of programs identified by your Board.

Discussion

Overview of the Mental Health Services Act

MHSA[1] is a law enacted by the California electorate through a ballot initiative, Proposition 63, at the November 2, 2004, General Election. Because of the relative recency of the Act, there are no reported court decisions related to the issues discussed in this memorandum. However, the Proposition itself and its implementing regulations are quite clear and specific regarding the intent of the Act, as set forth, below.

The Act provides dedicated funds to expand county mental health programs by: (1) imposing a one percent personal income tax surcharge on taxpayers with annual incomes of more than $1 million; and (2) preventing future State funding allocations for county mental health programs from falling below the levels in place immediately preceding the law's enactment. The Act mandates that the dedicated funds be set aside in a special fund for distribution to the

[1] The MHSA includes sections in the Revenue and Taxation Code, and the various sections in the Welfare and Institutions Code ("WIC"); this memorandum only addresses those provisions found in WIC section 5830 et seq.

counties, thereby protecting MHSA funds from being diverted by the Legislature and/or Governor during the annual State budget process. The Act also prohibits supplanting with MHSA funds any existing State or county funds utilized to provide mental health services.

MHSA Plan Components

Under the MHSA, funding is provided for county mental health programs to address a broad continuum of prevention, early intervention, and service needs, and for infrastructure, technology, and training needs. The MHSA specifies five major MHSA program components for which funds may be used and the percentage of funds to be devoted to each component. These components are: Community Services and Supports[2] ("CSS"), Capital Facilities and Technological Needs[3] ("CFTN"), Workforce Education and Training[4] ("WET"), Prevention and Early Intervention[5] ("PEI"), and Innovation[6] ("INN"). For these various components, county mental health departments must develop and submit program and expenditure plans ("County Plans"), which are typically three-year plans, and annual updates.

Development of Plans

Stakeholder involvement is integral to the MHSA, with such participation required both by the Act and by the regulations adopted to implement the Act. The MHSA itself requires that each County Plan and update "*shall be developed with local stakeholders.*"[7] The MHSA specifies the stakeholders to be included: "*adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans,*

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[2] Referred to in the Act as "System of Care Services"; these are programs that serve children (including transitional age youth), adults, and older adults.

[3] This addresses needed improvements or replacement of technology systems and capital projects to meet MHSA program infrastructure needs.

[4] This targets workforce development to remedy the shortage of qualified individuals to provide services to address severe mental illness.

[5] This supports the design of programs to prevent mental illness from becoming severe and disabling, with emphasis on access to services for the unserved and underserved populations.

[6] This supports development and implementation of promising practices designed to increase service access and improve quality and outcomes and promote interagency collaboration.

[7] WIC section 5848, subdivision (a).

representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and as well as other important interests."[8]

MHSA implementing regulations, set forth in California Code of Regulations ("CCR's"), elaborate extensively on the stakeholder participation requirement, including specifying the following:

"*The County*[9] *shall develop the Three-Year Program and Expenditure Plans and updates in collaboration with stakeholders, through the Community Program Planning Process . . . . County programs and/or services shall only be funded if the Community Program Planning Process set forth in these regulations was followed.*"[10]

"Community Program Planning" is defined by the regulations to mean "*the process to be used by the County to develop Three-Year Program and Expenditure Plans and updates in partnership with stakeholders to: (1) Identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the Mental Health Services Act. (2) Analyze the mental health needs in the community. (3) Identify and re-evaluate priorities and strategies to meet those mental health needs.*"

The regulations reiterate that the Community Program Planning Process requires "*Ensuring that stakeholders have the opportunity to participate in the Community Planning Process.*"[11]

Further, the regulations require that the "*Community Program Planning Process shall, at a minimum, include: (1) Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process. (2) Participation of stakeholders.*"[12]

Mental Health Commission Public Hearing

In addition to stakeholder participation, the Act and its implementing regulations require all County Plans and updates to be circulated

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[8] WIC section 5328, subdivision (a).

[9] As used in the regulations, "County" means the County Department of Mental Health.

[10] 9 CCR section 3310, subdivision (d).

[11] 9 CCR section 3300, subdivision (b)(3).

[12] *Ibid.* at section 3000, subdivision (c).

and posted for 30 days for review and comment,[13] and that the local mental health commission conduct a public hearing on the proposed County Plan.[14]

Submission of County Plans

County Plans must be submitted to the State Mental Health Services Oversight and Accountability Commission[15] ("Accountability Commission"). Until March 24, 2011, the Accountability Commission was responsible for annually reviewing and approving County Plans for expenditures for mental health services, and the State Department of Mental Health ("State DMH") was responsible for subsequently approving such plans. While State DMH's approval was a prerequisite to a county's receipt of MHSA funds, its review was limited to "ensuring the consistency of such [mental health] programs with other portions of the plan." In an effort to streamline the State approval process, the Legislature enacted AB 100,[16] eliminating the requirement that State DMH and the Accountability Commission annually review and approve County Plans and updates, and directing, effective July 1, 2012, that MHSA funds be distributed on a monthly basis to counties.

In passing AB 100, the Legislature made clear that streamlining the approval process was not to be at the expense of accountability. AB 100 states: "*It is the intent of the Legislature to ensure continued state oversight and accountability of the Mental Health Services Act. In eliminating state approval of county mental health programs, the Legislature expects the state in consultation with the [Accountability Commission], to establish a more effective means of ensuring that county performance complies with the Mental Health Services Act.*"[17]

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[13] WIC section 5848, subdivision (a); 9 CCR section 3315, subdivision (a)(1).

[14] WIC section 5848, subdivision (b); 9 CCR section 3315, subdivision (a)(2).

[15] The MHSA created this new oversight commission which is comprised of a 16-member voting commission; the 16 voting members include various stakeholder representatives (e.g., two persons with a severe mental illness, a family member of a child and of an adult or older adult with severe mental illness) and specified elected State officials (e.g., the Attorney General or her designee).

[16] Stats. 2011 Ch. 5, section 4 (AB 100). This was an urgency measure signed by the Governor on March 24, 2011, which included a number of other provisions intended to address the State's fiscal emergency.

[17] Stats. 2011 Ch. 5, section 1, subdivision (b) (AB 100).

New Requirements

The following year, the Legislature enacted AB 1467.[18] This legislation imposes a number of additional requirements on counties prior to the submission of County Plans to the Accountability Commission.[19] First, County Plans and updates must include a certification by the county mental health director that "the county has complied will all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and non-supplantation requirements." Second, County Plans must include certification by the county mental health director and county auditor-controller that "the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services[20] and that all expenditures are consistent with the requirements of the Mental Health Services Act." Third, County Plans and updates are required to be "adopted" by the county board of supervisors.

Effect of Recent Changes to the MHSA

The recent change to the MHSA requiring your Board's adoption of a County Plan or update prior to its submission to the Accountability Commission has raised questions as to your Board's authority to now direct that MHSA funding be used to fund a particular mental health program or programs or to fund specified services.

It is our opinion, after a careful review of the Act, its implementing regulations, and the legislative analyses related to these recent changes, that your Board's role in adopting County Plans and updates is one of oversight and, thus, is limited to ensuring that the MHSA processes and procedures have been followed and that the County Plans for programs and expenditures are consistent with the Act, and do not violate it or any other laws.[21]

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[18] Stats. 2012 Ch. 23. This is a budget trailer bill signed by the Governor on June 26, 2012.

[19] This legislation also requires that adopted County Plans for Innovation programs be approved by the Accountability Commission before a county may expend funds.

[20] The State Department of Health Care Services has assumed many of the functions previously preformed by the State Department of Mental Health.

[21] This includes requirements for stakeholder participation in developing plans; 30-day circulation and posting for public comment; public hearing by the County's mental health commission, and non-supplantation.

This conclusion is based on a number of considerations. First and foremost the Act makes clear that it must be "broadly construed to accomplish its purposes." Thus, any change should not be read as fundamentally altering the terms or spirit of the Act.

Further, any *amendment* to this voter-passed initiative requires a 2/3 vote of the Legislature and the amendment must be consistent with and further the intent of the Act. However, by majority vote the Legislature may *clarify* procedures under the Act.[22] AB 1467 was not enacted by a 2/3 vote of the Legislature and, according to the Legislative Counsel's Digest, was expressly intended to merely *clarify* the Act. Accordingly, the addition of the phrase "adopted by the county board of supervisors" must be read more modestly—the change should be viewed as a refinement to the process—not as fundamentally altering the process.

Consequently, to interpret the reference in the Act to the "county board of supervisors" as now permitting your Board greater authority than previously possessed to fund specific programs or activities or to do so outside of the established stakeholder processes, would be inconsistent with the purposes and intent of the Act and contrary to the Legislature's stated purpose for this revision.

This conclusion is further supported by the fact that at the same time that AB 1467 added language to the MHSA referencing the county board of supervisors, the legislation also added provisions to the MHSA reiterating the importance of the stakeholder process. The Legislature, as noted above, revised the Act to now require certification by the County of stakeholder participation, and the Legislature clarified that stakeholder participation means: "*Counties must demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.*"[23]

Further, it is clear the Legislature did not intend to provide greater authority to county boards of supervisors with respect to County Plans than was previously held by the State. The added provision referencing the County boards of supervisors states: "*Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and*

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[22] MHSA, Section 18, as adopted by the voters.

[23] WIC section 5848, subdivision (a).

Accountability Commission within 30 days after adoption."[24] Notably, the provision requires your Board's "adoption" of the County Plan, and not your Board's "approval." We believe this distinction is important, as "adoption" indicates only your formal acceptance of the County Plan. We do not believe that it requires your Board's agreement.

For these reasons, we believe that adoption of the County Plan by your Board is intended as one of several means to fill the void left by the Legislature when it eliminated the requirement for State review and approval of County Plans; it is not intended to diminish in any way the role of the stakeholders, a cornerstone of the MHSA, in developing those County Plans or to fundamentally alter established MHSA processes.

Adoption of County Plans by your Board

When DMH presents to your Board a County Plan for adoption, we believe that your Board may adopt the plan, or a part of the plan, or refer the plan, or a part of the plan, back to the stakeholder process.

In order for your Board to adopt a County Plan,[25] in whole or in part, the County Plan must be consistent with the MHSA and its regulations.

- All mandated procedural requirements must have been followed, including stakeholder participation, public comment, and a mental health commission public hearing.

- The County Plan or update must meet the non-supplantation requirements.

- Finally, it cannot violate the MHSA or other laws or regulations.

Your Board may not adopt a County Plan or any portion thereof that does not meet the above criteria. If presented with such a plan or update, the County Plan or update should be referred back for revision to the stakeholder process with your findings.

Your Board may also refer a plan back to the stakeholder process should your Board have questions or require clarity with respect to its content. Your Board is also permitted to refer a plan back to the stakeholder process for

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[24] WIC section 5847, subdivision (a).

[25] The same principles apply to Plan updates.

the stakeholders to consider changes to the content of a plan recommended by your Board, but your Board may not mandate that the stakeholder-developed plan include your Board's recommended changes.

Conclusion

The clear intent of the Act is that plans be developed, procedurally and substantively, through the stakeholder process set forth in the Act. Under the new legislation, these plans are now to be "adopted" by your Board before submission to the State. Your Board is now the oversight agency to ensure that plans are adopted in accordance with the procedural and substantive provisions of the Act, and are not otherwise in conflict with law. Plans meeting these criteria are to be "adopted" by your Board and submitted to the State.

If you have questions concerning this matter, please contact me, Assistant County Counsel Richard K. Mason at (213) 974-1866, or Principal Deputy County Counsel Stephanie Jo Reagan at (213) 974-0941.

JFK:SJR:ec

c: William T Fujioka
Chief Executive Officer

Sachi A. Hamai, Executive Officer
Board of Supervisors

Marvin J. Southard, D.S.W., Director
Department of Mental Health